Introduction:
Using the CMS/HCFA 1500 Claim Form

The CMS 1500 form, previously known as the HCFA 1500 form, is a billing form maintained by the National Uniform Billing Committee (NUBC). Each payer, including MaineCare, has different requirements for completing specific parts of the claim form.

You are responsible for obtaining your own CMS/HCFA 1500 forms; the Maine Department of Health and Human Services (DHHS) doesn't provide them.

CMS/HCFA 1500 forms are red printing on white paper. You can buy the forms at office supply centers and from other sources including:

U.S. Government Printing Office
Mail Stop: IDCC
732 N. Capitol St. NW
Washington, DC 20401

http://www.gpo.gov/

Cover the Bar Code

If you purchase a CMS/HCFA 1500 form that has a bar code in the upper left-hand corner, you must cover the bar code before submitting the form. We recommend a white sticker to cover the bar code. The bar code area is where DHHS stamps your claim's unique Transaction Control Number (TCN).

Who Must Use the CMS/HCFA 1500

If you are one of the following providers, you must use the CMS/HCFA 1500 form:

Advance Practice Registered Nursing Services

Ambulances

Ambulatory Care Clinics

Ambulatory Surgical Centers

Audiologists

Chiropractic Services

Community Support Services

Consumer Directed Attendant Services

Day Habilitation Services for Persons with Mental Retardation

Day Health Services

Day Treatment Services

Developmental and Behavioral Clinics

Medical Supplies and Durable Medical Equipment

Early Intervention Services

Family Planning Clinics

Federally Qualified Health Centers

Genetic Testing and Clinical Genetic Services

Hearing Aids and Services

Home and Community Based Benefits for the Elderly and for Adults with Disabilities

Home and Community Based Benefits for Members with Mental Retardation

Home and Community Based Benefits for the Physically Disabled

Home Based Mental Health Services

Independent Laboratories

Licensed Clinical Social Workers, Licensed Clinical Professional Counselors, and Licensed Marriage and Family Therapist Services

Medical Imaging Services

Occupational Therapy Services

Optometrists

Outpatient Mental Health Providers

Physical Therapy Services

Physician Services

Psychological Services

Podiatrist Services

Rehabilitation Services

Rural Health Clinic Services

School Based Rehabilitation Services

Speech and Hearing Services

Substance Abuse Treatment Services

Targeted Case Management Providers

Transportation/Wheelchair Van Services

VD Clinics

Vision Services

You May Need Special Instructions

Some providers who use the CMS/HCFA 1500 form need to follow special instructions for certain fields. If you are a specialty provider, look for *Special Instructions:* and the appropriate icon for you:

MH Mental Health Providers

QMB For a member who has QMB ("Quimby") eligibility

SA Substance Abuse Service Providers

TRANS/AMB Full Service Transportation/Wheelchair Van and Ambulance Providers

Also look for these icons:

Attach reminds you where you need to attach documentation for this claim.

➔ **Appendix** reminds you to check the Appendices for information such as billing for Medicare or other insurance.

Appendix A is on Page 40; Appendix B is on Page 42; and Appendix C is on Page 43.

Required and Not Required Boxes and Fields

Boxes and fields that are not required are shaded. All required boxes are clear.

Not Required:

Box 1:

1. MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
☐ (Medicare #)	☐ (Medicaid #)	☐ (Sponsor's SSN)	☐ (VA File #)	☐ (SSN or ID)	☐ (SSN)	☐ (ID)

Not required.

Required:

Box 28: TOTAL CHARGE

28. TOTAL CHARGE
$

Total the charges in Box 24, Column F, and enter that amount here.

Example:

28. TOTAL CHARGE
$ 1102 00

Please note, although some boxes are not required, they are also not shaded. This is because DHHS recommends that you enter special information in these boxes. This optional information, such as the patient's account number, will help you in your recordkeeping.

Examples and Additional Help

The instructions for each required box or field include an example of what the completed box or field should look like. In some boxes that have special instructions for specific providers, there are additional examples.

The instructions also give you important information and help.

Look for these icons:

ALERT:

TIP:

Additional Tips on Filing

Here's other important information you need to know before you begin filling out your form:

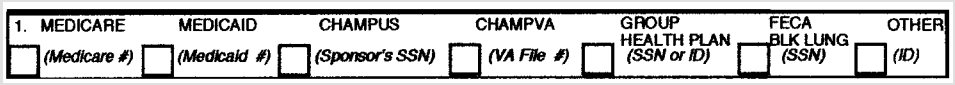
- Use current CPT (Current Procedural Terminology) of the American Medical Association, ICD 9 (International Classification of Diseases) Diagnostic Codes, or HCPCS (Healthcare Common Procedure Coding System) Codes maintained by the Centers for Medicare and Medicaid Services. Or,
- Use the Procedure Codes in Chapter III of the *MaineCare Benefits Manual* policy section under which you bill. You may access these codes at the following website: http://www.maine.gov/sos/cec/rules/10/ch101.htm
- The required format for a birth date is MMDDYYYY. (Example: January 19, 1947 = 01191947) This is the Y2K-compliant format.
- The alternative date format for dates of service or signature dates is MMDDYY. DHHS will process your claim if you use that format, but we recommend that you transition to the eight-digit Y2K-compliant format.
- Whether you fill in your claim form by typing, computer, or handwriting, keep all information within the designated boxes. Don't overlap information into other fields.

The following are the step-by-step instructions for completing each box or field in the CMS/HCFA form.

Step-by-Step Instructions for Completing The CMS/HCFA 1500 Claim Form

Boxes 1, 1a

Box 1:



Not required.

Box 1a: INSURED'S I.D. NUMBER

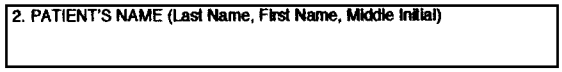
Enter the member's MaineCare ID number exactly as shown on the member's MaineCare ID card.

Example:

TIP:

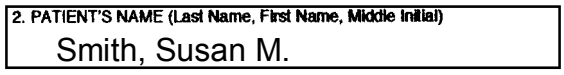
You must verify the member's eligibility status. Use the swipe card system or the Interactive Voice Response (IVR) system at 1-800-452-4694 or 207-287-3081.

BOX 2: PATIENT'S NAME

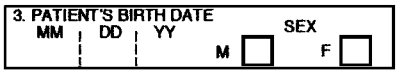


Enter the member's last name, first name and middle initial (if any) as shown on his/her MaineCare ID card. If the member's name on the ID card has an apostrophe or a hyphen, you may use that punctuation.

Example:



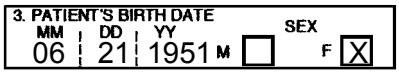
BOX 3: PATIENT'S BIRTH DATE AND SEX



Enter the month, day and year the member was born. The format for a birth date must be MMDDYYYY.

Enter an X in the appropriate M or F checkbox for the member's sex.

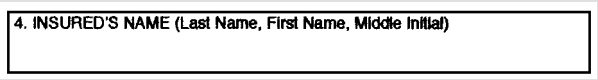
Example:



TIP:

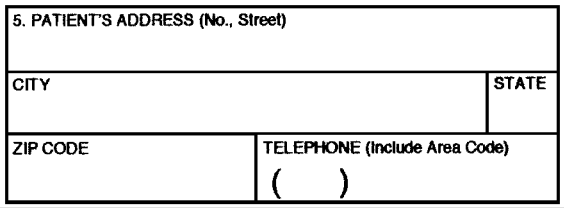
Throughout this form, please enter information within the boundaries of each box or field. Do not overlap into other boxes or fields.

Box 4: INSURED'S NAME



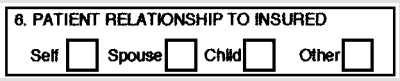
Not required.

Box 5: PATIENT'S ADDRESS



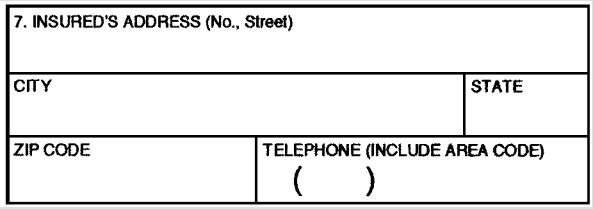
Not required.

Box 6: PATIENT RELATIONSHIP TO INSURED



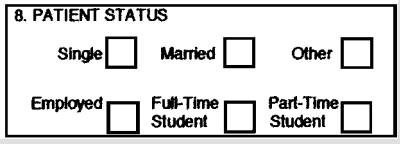
Not required.

Box 7: INSURED'S ADDRESS



Not required.

Box 8: PATIENT STATUS



Not required.

BOX 9: OTHER INSURED'S NAME

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY	SEX M ☐ F ☐
c. EMPLOYER'S NAME OR SCHOOL NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	

If the member is covered by a primary insurance other than MaineCare, enter the name of the policyholder. Do not enter Medicare or any other State program information. If you complete this box, also complete Boxes 9a, 9b, 9c, and 9d. Instructions for Boxes 9a–9d are on the next page.

If there is no other insurance, leave this box and all fields (9–9d) blank.

Example:

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
Smith, John M.	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	
111-11-1111	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY	SEX M ☒ F ☐
06 16 1947	
c. EMPLOYER'S NAME OR SCHOOL NAME	
Acme Corp.	
d. INSURANCE PLAN NAME OR PROGRAM NAME	
Anthem Blue Cross Plan B	

ALERT:

You must submit the claim to other insurers prior to submitting the claim to MaineCare.

Box 9a: OTHER INSURED'S POLICY OR GROUP NUMBER

Enter the policy or group number of the primary insurance.

Box 9b: OTHER INSURED'S DATE OF BIRTH AND SEX

Enter the month, day and year the policyholder was born. The format for a birth date must be MMDDYYYY. Do not use hyphens, commas or slashes between numbers.

Enter an X in the appropriate checkbox for the policyholder's sex.

Box 9c: EMPLOYER'S NAME OR SCHOOL NAME

Enter the policyholder's employer or school, if applicable.

Box 9d: INSURANCE PLAN NAME OR PROGRAM NAME

Enter the name of the primary insurance plan or program name. (Example: Anthem Blue Cross Plan B.) Do not enter Medicare or MaineCare in this field.

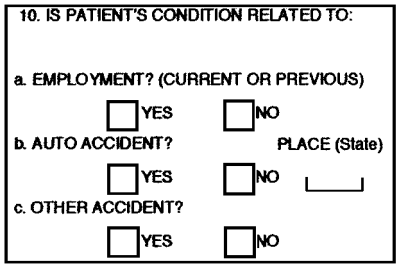
Example:

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
Smith, John M.	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	
111-11-1111	
b. OTHER INSURED'S DATE OF BIRTH MM | DD | YY	SEX
06 | 16 | 1947	M [X] F [ ]
c. EMPLOYER'S NAME OR SCHOOL NAME	
Acme Corp.	
d. INSURANCE PLAN NAME OR PROGRAM NAME	
Anthem Blue Cross Plan B	

ALERT:

You must submit the claim to other insurers prior to submitting the claim to MaineCare.

Box 10: IS PATIENT'S CONDITION RELATED TO:



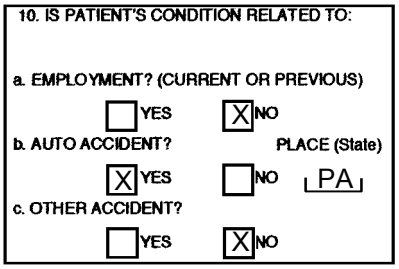
If applicable, enter an X in each appropriate checkbox (a, b, and c). If a, b, and c are not applicable, you may leave those checkboxes blank.

Box 10a: EMPLOYMENT? (CURRENT OR PREVIOUS)

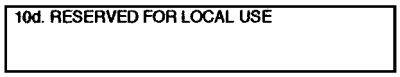
Box 10b: AUTO ACCIDENT? / PLACE (STATE)

Box 10c: OTHER ACCIDENT

Example:

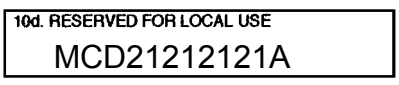


Box 10d: RESERVED FOR LOCAL USE



If you are submitting this claim to Medicare prior to MaineCare, enter the member's MaineCare ID number. As shown below, enter the letters MCD followed by the member's MaineCare ID number. The number will be transmitted as part of the automated Medicare crossover system.

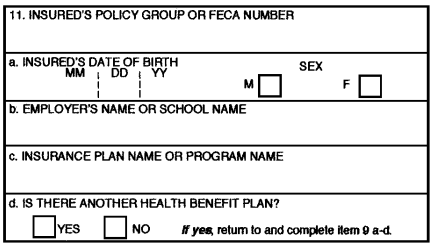
Example:



ALERT:

If the MaineCare ID is not entered in 10d, the claim may not cross over to Medicare.

Box 11: INSURED'S POLICY GROUP OR FECA NUMBER



If YES is checked in Box 11d, enter the policy or group number. Do not enter Medicare or any other State program.

Box 11a: INSURED'S DATE OF BIRTH AND SEX

If YES is checked in Box 11d, enter the month, day and year the policyholder was born. The format for a birth date must be MMDDYYYY.

Enter an X in the appropriate box for the policyholder's sex.

Box 11b: EMPLOYER'S NAME OR SCHOOL NAME

If YES is checked in Box 11d, enter the name of the policyholder's employer or school.

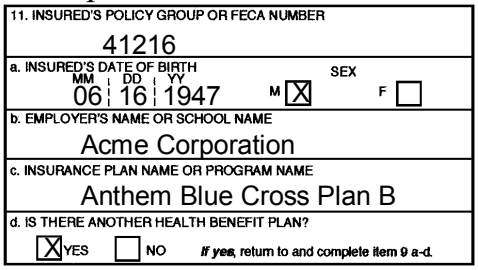
Box 11c: INSURANCE PLAN NAME OR PROGRAM NAME

If YES is checked in Box 11d, enter the name of the policyholder's insurance plan or program. Do not enter Medicare or the name of any other State program.

Box 11d: IS THERE ANOTHER HEALTH BENEFIT PLAN?

If the MaineCare member is covered by other primary insurance and he/she is not the policyholder, enter an X in the YES box and also complete Fields 9a–9c. Do not check the YES box if the member has Medicare or is covered by any other State program. If there is no other insurance, enter an X in the NO box.

Example:



Box 12: PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

Not required.

Box 13: INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

Not required.

Box 14: DATE OF CURRENT ILLNESS, INJURY OR PREGNANCY

14. DATE OF CURRENT: MM | DD | YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

Not required.

Box 15: IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM | DD | YY

Not required.

Box 16: DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
MM | DD | YY FROM MM | DD | YY TO

Not required.

Box 17: NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

Not required.

Box 17a: I.D. NUMBER OF REFERRING PHYSICIAN

17a. I.D. NUMBER OF REFERRING PHYSICIAN

If the member is enrolled in MaineCare Managed Care and the service requires a referral number from the Primary Care Provider (PCP) site, enter the PCP's site-specific, 9-digit referral number.

Example:

17a. I.D. NUMBER OF REFERRING PHYSICIAN
000203000

For additional information regarding MaineCare Managed Care, please use the following website:
http://www.maine.gov/dhhs/bms/providerfiles/provider_managed_care.htm

Box 18: HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

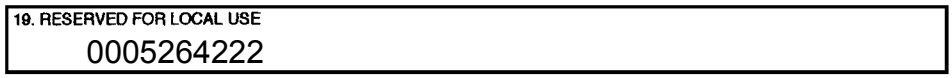
Not required.

Box 19: RESERVED FOR LOCAL USE

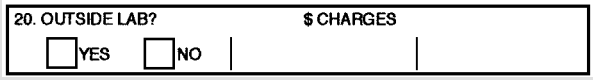
If you are billing a J code in Box 24D, enter the National Drug Code (NDC) for that drug. Do not enter the description of the drug, and do not enter NDC before the actual NDC code.

Only one J code may be billed per claim.

Example:

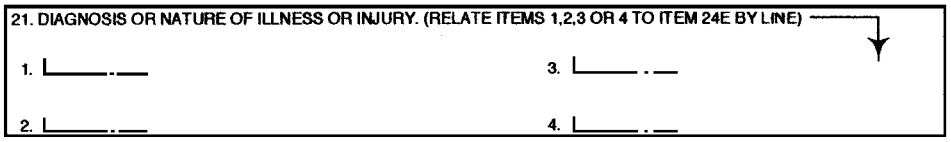


Box 20: OUTSIDE LAB?



Not required.

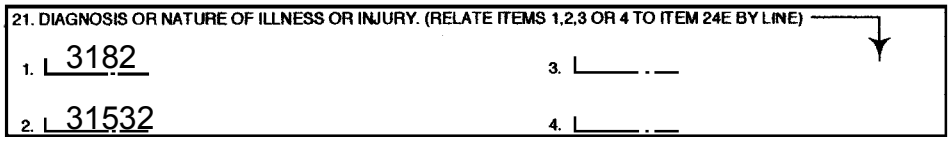
Box 21: DIAGNOSIS OR NATURE OF ILLNESS OR INJURY



On the line after 1., enter the numeric International Classification of Diseases (ICD-9) code only. Use the code that is as specific as possible, according to ICD-9 coding guidelines. Do not enter the description of the diagnostic code.

If there is more than one diagnosis, enter each code on the line after 2., 3., and 4. You may not enter more than four diagnoses.

Example:



Special Instructions:

TRANS Full Service Transportation/Wheelchair Van Providers only: Not required.

ALERT:

As a Provider, you are expected to have up-to-date code books for diagnoses and procedure codes.

Box 22: MEDICAID RESUBMISSION CODE/ORIGINAL REF. NO.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

Not required.

Box 23: PRIOR AUTHORIZATION NUMBER

23. PRIOR AUTHORIZATION NUMBER

If applicable, enter the 9-digit Prior Authorization number issued by the authorizing unit for the services or supplies being billed on this form. You may bill only one Prior Authorization number on each claim form.

Example:

23. PRIOR AUTHORIZATION NUMBER
050402001

ALERT:

If you are a LCSW, LCPC, or LMFT billing under Chapter II, Section 58 of the *MaineCare Benefits Manual*, all services require a Prior Authorization number.

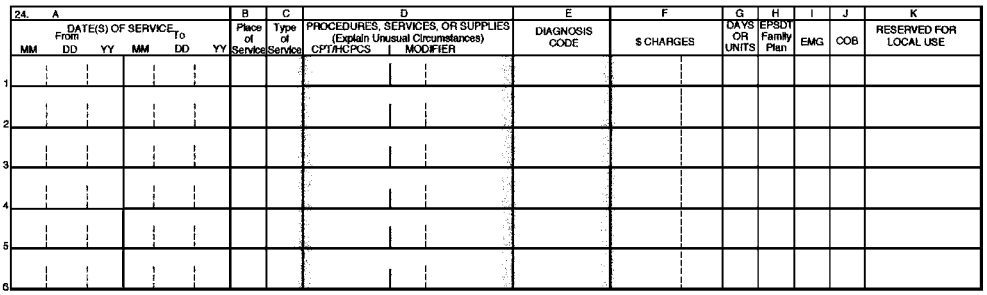
For all other Providers, refer to Chapter I, or the applicable policy of the *MaineCare Benefits Manual.*

BOX 24: (BOX HAS NO TITLE)

➔ Appendix A: If you are allowed to bill for Medicare coinsurance and deductible (you <u>are</u> a Provider listed in Box 24J), see Appendix A, Page 40, for billing coinsurance and deductible.

➔ Appendix B: If you are billing after Medicare and you <u>are not</u> a Provider listed in Box 24J, see Appendix B, Page 42.

➔ Appendix C: If you are billing after commercial insurance, see Appendix C, Page 43.



24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1																
2																
3																
4																
5																
6																

ALERT:

This claim is limited to six lines.

For each line item billed, you must include one date, one place of service, one procedure code, and one amount charged per line.

See the following pages for instructions for Boxes 24A–24K.

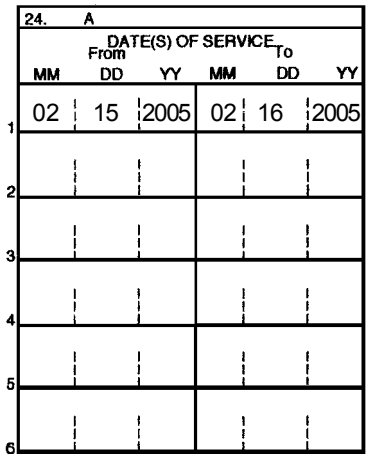
Box 24A

Box 24A: DATE(S) OF SERVICE

Enter both "From" and "To" dates of service. The preferred format is MMDDYYYY, though you may also use MMDDYY format.

Dates must be consecutive and continuous. If the service was provided on only one day, just put that date in the From field.

Example:



Box 24B: PLACE OF SERVICE

Enter a two-digit Place of Service code from the following list:

03 School
04 Homeless Shelter
08 Tribal 638 Provider Based Facility
11 Office
12 Home
13 Assisted Living Facility
14 Group Home
15 Mobile Unit
20 Urgent Care Facility
21 Inpatient Hospital
22 Outpatient Hospital
23 Emergency Room – Hospital
24 Ambulatory Surgical Center
25 Birthing Center
32 Nursing Facility
33 Custodial Care Facility
41 Ambulance – Land
42 Ambulance – Air or Water
49 Independent Clinic
50 Federally Qualified Health Center
51 Inpatient Psychiatric Facility
52 Psychiatric Facility – Partial Hospitalization
53 Community Mental Health Center
54 ICF/MR
55 Residential Substance Abuse Treatment Facility

(Code list continued on next page.)

ALERT:

Early Intervention Programs: Use Place of Service code 99.

Full Service Transportation/ Wheelchair Van Providers: Use the Place of Service code you transported the member to.

Durable Medical Equipment and Supplies Providers: Use the Place of Service code where the member resides.

(Place of Service codes continued)

56 Psychiatric Residential Treatment Facility

57 Non-Resident Substance Abuse Treatment Facility

61 Comprehensive Inpatient Rehabilitation Center

62 Comprehensive Outpatient Rehabilitation Center

65 End Stage Renal Disease Treatment Facility

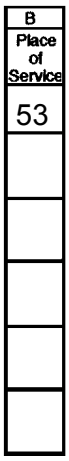
71 State or Local Public Health Clinic

72 Rural Health Clinic

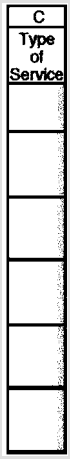
81 Independent Laboratory

99 Other Place of Services

Example:



Box 24C: TYPE OF SERVICE

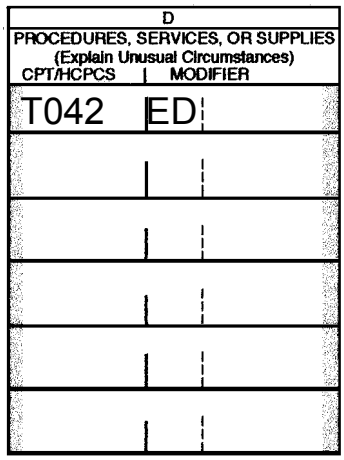


Not required.

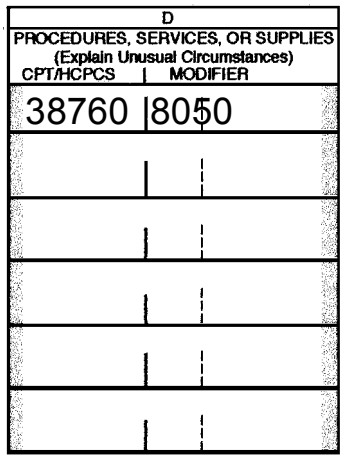
Box 24D: PROCEDURES, SERVICES OR SUPPLIES

Enter the appropriate procedure code and modifier(s), if necessary. Procedure codes and modifiers are in Chapter III of the *MaineCare Benefits Manual* and on the Office of MaineCare Services website, http://www.state.me.us/bms/bmshome.htm

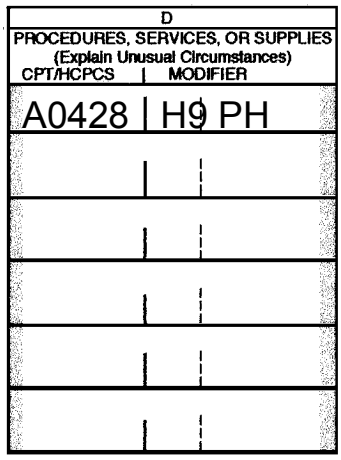
Transportation Example:



Physician Example:



Ambulance Example:



(Instructions for 24D continued on next page.)

Special Instructions for 24D continued:

TRANS/AMB Full Service Transportation/Wheelchair Van and Ambulance Providers:

In the Modifier field, enter the appropriate two letters for the transport's place of origin and destination from the following list (as shown in the example above):

D. Diagnostic or therapeutic site other than P or H.

E. Residential domiciliary, custodial facility (nursing home, not skilled nursing facility)

G. Hospital-based dialysis facility (hospital or hospital-related)

H. Hospital

J. Non-hospital-based dialysis facility

N. Skilled nursing facility (SNF)

P. Physician's office (includes HMO non-hospital facility, clinic, etc.)

R. Residence

Use of Modifier U1: Please see instructions for Box 24K.

Box 24E: DIAGNOSIS CODE

From Box 21, enter the line number or numbers (1, 2, 3, and/or 4) that list the diagnosis codes. Do not enter the codes themselves. List only the line numbers.

Example:

E DIAGNOSIS CODE
1
1,3
2,3
1,2,3
2,4
1,2,3,4

Special Instructions:

TRANS Full Service Transportation/Wheelchair Van Providers only: Not required.

Box 24F

Box 24F: $ CHARGES

Enter the charge for the service you provided based on the policy section under which you are billing.

For more information on charges, see the *MaineCare Benefits Manual* (http://www.maine.gov/sos/cec/rules/10/ch101.htm).

➔ Appendix A: If you are allowed to bill for Medicare coinsurance and deductible (you are a Provider listed in Box 24J), see Appendix A, Page 40.

QMB If a member has QMB eligibility only and Medicare has approved the service, follow the instructions in Appendix A for billing Medicare coinsurance and deductible. If Medicare has not approved the service, no reimbursement is available.

➔ Appendix B: If you are not listed in Box 24J and you are billing after Medicare, see Appendix B, Page 42.

➔ Appendix C: If you are billing after commercial insurance, see Appendix C, Page 43.

If you are submitting for services that have been prior authorized, you must enter the lower of your usual and customary charges, or enter the prior authorized amount.

Example:

F
$ CHARGES
55 00

☞ **TIP:**

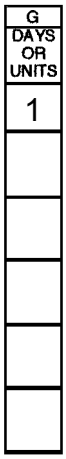
Do not put a $ sign before the total. The $ can be picked up as an 8.

BOX 24G: DAYS OR UNITS

Enter the number of days of service or the units of supplies provided. Do not use decimal points or fractions. Round off to the nearest whole number. Enter 1 only if 1 unit was provided. (For example: For Indian Health Centers or Rural Health Centers, 1 unit of a visit is 1, not the units of itemized services provided in that visit.)

To find the definition of a unit, refer to the code descriptions or maximum allowance column in Chapter III of the *MaineCare Benefits Manual*, or refer to the CPT and HCPCS standard code listings.

Example:



ALERT:

Do not leave this field blank.

Box 24H: EPSDT FAMILY PLAN

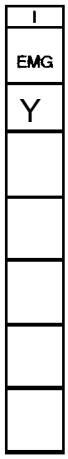
Not required.

Box 24I: EMG

Enter a Y to prevent copay from being deducted if you are billing services that are exempt from copay.

Refer to Chapter I of the *MaineCare Benefits Manual* for a list of services exempt from copays.

Example:



TIP:

This box replaces the EMR diagnosis code that previously was used to bypass copay according to Chapter I.

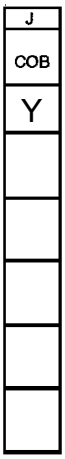
Box 24J

24J: COB

Enter a Y when billing for Medicare coinsurance or deductible and if you are one of the following:

Ambulance
Ambulatory Care Clinic
Indian Health Center
Advanced Nurse Practitioner
Mental Health Clinic
Optometrist
Physician
Podiatrist
Psychologist
QMB/"Quimby" Provider
(See Special Instructions below)
Federally Qualified Health Center
Rural Health Center

Example:



Special Instructions:

QMB If the member has QMB eligibility only and Medicare has approved the service, enter a Y. See Appendix A, Page 40, for billing Medicare coinsurance and deductible—even if you are not a provider type listed above. If Medicare has not approved the service, no reimbursement is available.

Box 24K

24K: RESERVED FOR LOCAL USE

Enter the Servicing Provider ID number, if applicable.

If a Servicing Provider ID number is not required, leave this field empty.

Example:

K
RESERVED FOR LOCAL USE
333333399

See Special Instructions for Box 24K on the next page, including a list of provider types that are not required to enter a Servicing Provider ID number.

TIP:

Refer to your MaineCare enrollment letter for your Servicing Provider ID number or numbers.

ALERT:

The Servicing Provider ID number always ends in 99.

Special Instructions for Box 24K

If you are one of the following Providers or services, a Servicing Provider ID number is not required in Field 24K:

- Ambulance
- Ambulatory Surgical Center
- BMR Waiver Provider – Section 21
- Case Management Provider – Section 17
- Community Support Services
  - CBB10
  - CBB17
- Consumer Directed Attendant Service – Section 12
- Day Habilitation Provider – Free Standing Day Habilitation billing under Section 24
- Day Health – Section 26
- Day Treatment Services Provider
- Developmental/Behavioral Clinic Provider – Section 23
- Durable Medical Equipment and Supplies Provider
- Early Intervention Program
- Full Service Transportation/Wheelchair Van Services
- Genetic Testing and Clinical Genetic Services – Section 62
- Home Based Mental Health Provider – Section 37
- Laboratory Services – Section 55
- Medical Imaging – Section 101

(List continued on next page.)

TIP:

Refer to your MaineCare enrollment letter for your Servicing Provider ID number or numbers.

ALERT:

The Servicing Provider ID number always ends in 99.

If a Servicing Provider ID number is not required, leave this field empty.

Special Instructions for Box 24K, continued (Provider types that are not required to enter a Servicing Provider ID number in Box 24K.)

Mental Health Agency

Children's Service Codes

Z4107 Day Treatment

Z4186 Child Crisis Support (per diem unit)

Z4187 Child Family & Community Support (per diem unit)

ZNC11 Family Psychoeducation

ZNC16 Child ACT

Adult Service Codes

Z4169 Adult Crisis Support (per diem unit)

Z4188 Psychoeducation

Optical Contractor

Rehabilitation Services Provider – Section 102

School Based Rehabilitation Provider

Substance Abuse Service Provider

H0015 Intensive Outpatient Services

H0020 Methadone Clinic Services

VD Screening Clinic Services – Section 150

ALERT:

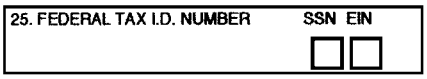
The Servicing Provider ID number always ends in 99.

Using Modifier U1 for services provided by "Other Qualified Staff": In Field 24D, if services were provided by "Other Qualified Staff," you must fill in the appropriate procedure code with the Modifier U1. You must then enter the Servicing ID number of the licensed clinical supervisor here (Field 24K).

ALERT:

Please note these instructions for Modifier U1.

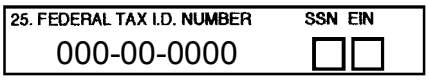
BOX 25: FEDERAL TAX I.D. NUMBER



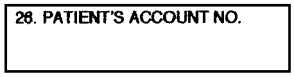
Although this is not required, you may enter this information. If the Provider ID number in Box 33 is incorrect or missing, the claims unit uses the information in this box to inform you that your claim is denied.

The SSN and EIN checkboxes are not required.

Example:



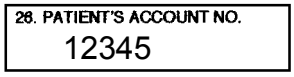
Box 26: PATIENT'S ACCOUNT NO.



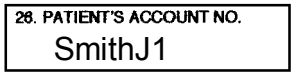
Although this box is not required, including the patient account number or the member's name here is highly recommended. If the MaineCare member's ID number in Box 1A is incorrect, the information you enter in this box will appear on your remittance statement. You will then be able to cross-reference the RA and your records.

If you are using a patient account number, enter the number (any alphanumeric combination up to 12 characters). If you don't use a patient account number, enter the member's name.

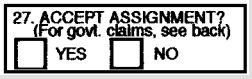
Example:



Or:

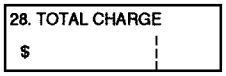


Box 27: ACCEPT ASSIGNMENT?



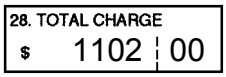
Not required.

Box 28: TOTAL CHARGE



Total the charges in Box 24, Column F, and enter that amount here.

Example:



Box 29: AMOUNT PAID

➔ Appendix: See Appendices A, B, and C, Pages 40–43, for billing after Medicare or other commercial insurances.

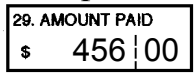
Attach the third party Explanation of Benefits (EOB) for all claims involving a third party when balance billing MaineCare after you have received payment or denial from the primary health plan.

- If payment was made, you must enter the amount of the insurance payment in Box 29, as well as attach the third party Explanation of Benefits (EOB).
- In order for the claims payment system to properly distribute third party payments, only those line items paid by the third party can be billed on the same claim form.
- Those charges that have been denied by the insurer, where no third party payment was made, must be billed on a separate claim form, and you must include the third party Explanation of Benefits (EOB).
- Do not enter the Medicare payment in Box 29 if you are billing for Medicare coinsurance or deductible.

Spenddowns: Enter the total amount of payments from third party payers. If you have been issued a spenddown letter from the Bureau of Family Independence, enter the patient responsibility amount. The dates and amounts on this claim must match the spenddown letter.

Attach the spenddown letter to this claim.

Example:



TIP:

Do not enter the member's anticipated copay amount. It will be automatically deducted in the claims process.

Box 30: BALANCE DUE

30. BALANCE DUE
$

Enter the balance due. Subtract the amount in Box 29 from the amount in Box 28. If Box 29 is greater than Box 28, enter 0. Do not enter negative numbers.

Example:

30. BALANCE DUE
$ 1102 00

Box 31: SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS

31. SIGNATURE OF PHYSICIAN OR SUPPLIER
INCLUDING DEGREES OR CREDENTIALS
(I certify that the statements on the reverse
apply to this bill and are made a part thereof.)

SIGNED DATE

Enter the Provider's name and billing date. The signature or name may be typed or stamped. The Provider's authorized person may sign. The name must be the name of an actual person.

Do not use "signature on file."

Degree or credentials are not required.

The preferred format for the billing date is MMDDYYYY, though you may also use MMDDYY format.

Example:

31. SIGNATURE OF PHYSICIAN OR SUPPLIER
INCLUDING DEGREES OR CREDENTIALS
(I certify that the statements on the reverse
apply to this bill and are made a part thereof.)

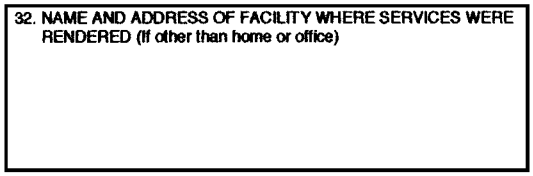
John M. Doe 02182005
SIGNED DATE

ALERT:

The signed date must be the same date or a date later than the last date of service on this form.

Services may not be billed before they are provided.

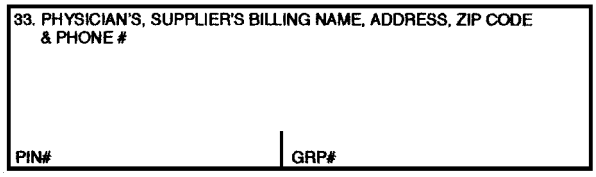
Box 32: NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED



If services were in a location other than the Provider's office or the member's home, enter the name and address of that facility.

Example:

BOX 33: PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE

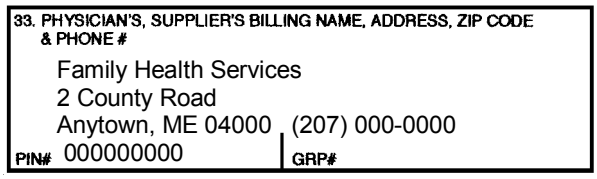


Enter the Provider's name, address, and 9-digit Billing Provider ID number. Be sure to enter the Provider ID number in the field directly to the right of PIN#. Do not enter the Servicing Provider ID number here.

A telephone number is not required. If you do include a phone number, please take care not to overlap the Provider ID number with the telephone number.

The GRP# is not required. Do not use GRP# for your Billing Provider ID number.

Example:



Appendix A

Billing Medicare Coinsurance and Deductible to MaineCare

Providers who are allowed to bill for coinsurance and deductible after Medicare

Important: You must bill any third party companion plans prior to billing MaineCare.

If you are one of the following Providers, you are allowed to bill for Medicare coinsurance and deductible:

- Ambulance
- Ambulatory Care Clinic
- Indian Health Center
- Advanced Nurse Practitioner
- Mental Health Clinic
- Optometrist
- Physician
- Podiatrist
- Psychologist
- QMB/"Quimby" Provider
- Federally Qualified Health Center
- Rural Health Center
- Member has QMB eligibility only

If you are one of the above, these are your special instructions:

If you choose not to use the crossover system, or the claim did not cross over properly, then you must complete the CMS/HCFA 1500 claim form according to MaineCare requirements, along with the following:

Box 21: You are required to use a diagnostic code.

Box 24D: Enter the procedure codes and modifiers normally billed to MaineCare.

Box 24F: Charges must reflect the sum of the Medicare coinsurance and deductible amounts as shown on the Explanation of Medicare Benefits (EOMB).

Box 24J: Enter a Y when billing for Medicare coinsurance and deductible.

Box 28: Enter the total charges. This must equal the total of the individual line item charges in 24F.

Box 29: Enter any other third party payment from an insurance company. Do not enter the Medicare payment.

Box 30: Enter the balance due. This cannot exceed the member responsibility shown on the Explanation of Benefits.

Attach a copy of the Explanation of Medicare Benefits (EOMB) and any third party Explanation of Benefits (EOB).

Appendix B

Billing Medicare Coinsurance and Deductible to MaineCare

Providers who are not allowed to bill for coinsurance and deductible after Medicare

Important: You must bill any third party companion plans prior to billing MaineCare.

Complete the CMS/HCFA 1500 claim form according to MaineCare requirements, along with the following:

Box 21: You are required to use a diagnostic code.

Box 24D: Enter the procedure codes and modifiers normally billed to MaineCare.

Box 24F: Enter the Medicare allowed amount as shown on the Explanation of Medicare Benefits (EOMB).

Box 28: Enter the total charges. This must equal the total of the individual line item charges in 24F.

Box 29: Enter the sum of the Medicare payment and any other third party payment from an insurance company.

Box 30: Enter the balance due. This cannot exceed the member responsibility shown on the Explanation of Medicare Benefits (EOMB).

Attach a copy of the Explanation of Medicare Benefits (EOMB) and any other third party Explanation of Benefits (EOB).

Appendix C

Third Party Billing Instructions

1. Balance Billing Traditional Insurance Plans and Fee For Service Managed Care Plans

2. Physicians Billing Copays for Capitated Services Under Managed Care Plans

1. For balance billing traditional insurance plans and fee for service managed care plans

Important: You must attach the third party Explanation of Benefits to the claim form.

Complete the CMS/HCFA 1500 claim form according to MaineCare requirements, along with the following:

Box 24F: Charges must equal the allowed amount that you and the insurance company agreed to, as shown on insurance company's Explanation of Benefits (EOB).

Box 28: Enter the total charges. This must equal the total of the individual line item charges in 24F.

Box 29: Enter the amount paid by insurance company/third party. The third party amount must equal the actual third party payment, plus any withheld amount shown on the insurance company's Explanation of Benefits. You must enter this amount on the claim form, and you must attach the Explanation of Benefits.

Box 30: Enter balance due. This cannot exceed the member responsibility shown on the Explanation of Benefits.

Please remember, if the third party payment exceeds the MaineCare rate for the service, there is no balance due.

Services not covered by the third party payer must be billed on a separate claim form with the Explanation of Benefits attached to the claim.

You cannot charge the patient the copay.

2. For Physicians billing copays for capitated services under managed care plans:

NOTE: Capitated services are services covered under the monthly capitation payment agreement between a managed care plan and the member's provider.

Complete the CMS/HCFA 1500 claim form according to MaineCare requirements, along with the following:

Box 24D: Enter the appropriate procedure code.

Box 24F: Charges must equal the copay amount.

Box 28: Enter the total copay charges. This must equal the total of the individual line item charges in 24F.

Box 29: Enter 0 (a zero).

Box 30: Enter amount from Box 28.

Attach a copy of the Explanation of Benefits (EOB).

You can only bill copays for capitated services under a managed care plan.

Services not covered by the third party payer must be billed on a separate claim form with the Explanation of Benefits (EOB) attached to the claim.

You cannot charge the patient the copay.